Drug Demand Reduction Program

USAID-funded Drug Demand Reduction Program in Uzbekistan, Tajikistan, and the Ferghana Valley Region of Kyrgyzstan (DDRP)

DDRP BEST PRACTICE COLLECTION

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DDRP best practice collection series includes:

- **Drug Demand Reduction Program**
- Unique Identifier Code
- "Sister to Sister"
- Treatment Readiness for Drug Users
- Drug free Treatment and Rehabilitation for Drug Users
- Drug free Public Social Spaces
- Drug Demand Reduction Education and Referral of Migrants
- Youth Power Centers
- "Break the Cycle"
- Youth Positive Development

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INTRODUCTION AND OVERVIEW

What is DDRP?

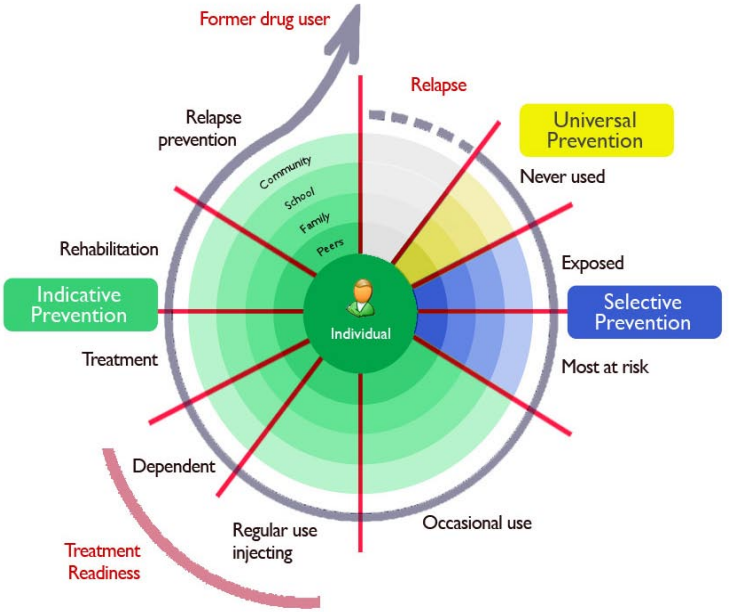
The USAID-funded Drug Demand Reduction Program (DDRP) aims to address social problems among vulnerable populations involved in or at-risk of involvement in drug use in Central Asia. DDRP activities in Uzbekistan, Tajikistan and the Ferghana Valley region of Kyrgyzstan are a response to the dramatic rise in opiate injection in the region.

The term "drug demand reduction" is used to describe policies or programs aimed at reducing the consumer demand for narcotic drugs and psychotropic substances covered by international drug control conventions [1]. The countries covered under this program have experienced significant increases in opiate consumption due to geography and recent sociopolitical events including the collapse of the Soviet Union and the Afghan conflict. Heroin transiting through these countries has created epidemics of drug use, undermining already fragile economies and threatening to overwhelm health systems with an HIV epidemic. This has also occurred in other nearby former Soviet republics. DDRP's mission is to engage all levels of society in reducing demand for heroin and other opiates. The program began in 2002 and will conclude in 2008.

A full spectrum of drug demand reduction (see Figure on page 3) incorporates universal prevention that educates the population at large in a public health approach towards decreasing drug use, selective prevention for individuals at-risk of using drugs, and indicated prevention which aims to reduce occasions of heroin/opiate use, minimize health risks associated with use, and move regular drug users towards treatment. This last element of indicative prevention is sometimes called "treatment readiness", which involves providing low-threshold, outpatient services such as counseling, stress reduction techniques, and other support to enable drug users to seek treatment. Treatment and rehabilitation of drug users are also key elements of drug demand reduction strategies.

The key components of DDRP include:

- educating target populations on drug-related issues;
- promoting healthy lifestyles;
- providing access to alternative occupational and leisure activities;

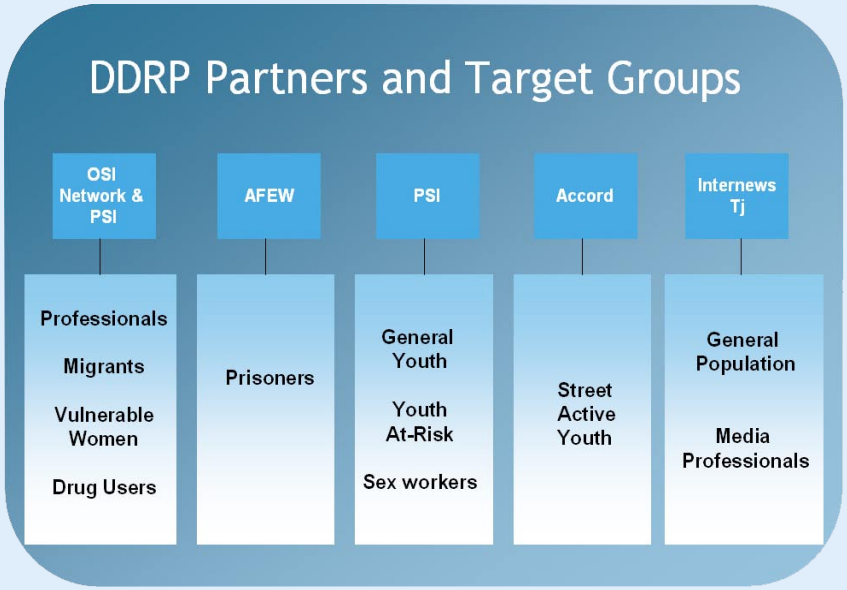


DDRP's Full Prevention Spectrum

- assisting in solving social problems;
- supporting the development of pragmatic drug demand-reduction strategies at national and local levels.

Who is implementing DDRP?

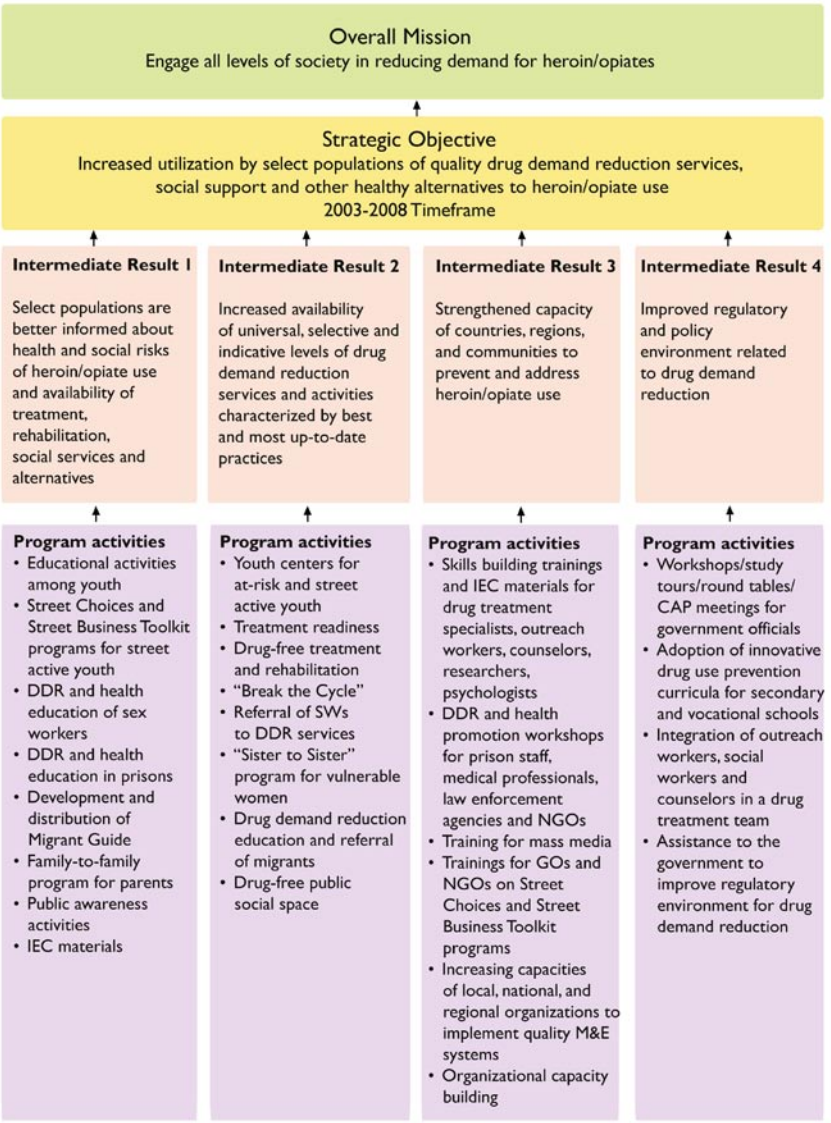
The Drug Demand Reduction Program involves a network of leading international organizations active in HIV prevention and drug demand reduction in the region. The main implementing agency for DDRP is the Alliance for Open Society International (AOSI). Program partners include: Population Services International (PSI), Community Development Center Accord (Accord), AIDS Foundation East-West (AFEW), Internews Tajikistan (Internews Tj), Open Society Institute Assistance Foundation – Tajikistan (OSIAF Tj), and the Soros Foundation Kyrgyzstan (SF Kg).



DDRP Pilot Sites

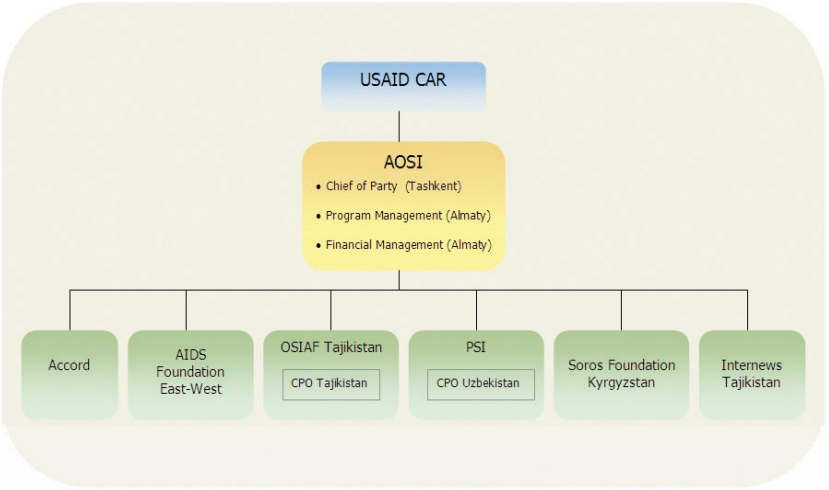
- **Uzbekistan**: Tashkent city; Tashkent, Samarkand, Surkhandariya and Ferghana provinces
- **Tajikistan**: Dushanbe city; Sughd, Khatlon and Gorno-Badakhshan Autonomous provinces
- **Kyrgyzstan**: Osh and Djalal Abad provinces

MISSION AND OBJECTIVES



Program management

As the primary grantee, one of AOSI's major roles is to increase coordination and cooperation amongst all six sub-grantee partners. The aim is to facilitate more unified and complementary program delivery. Existing formal coordination mechanisms include: quarterly partner meetings in Almaty organized by AOSI, quarterly country coordination meetings organized by DDRP Country Program Offices (CPO), quarterly program and financial reports, Technical Review Committees (TRC) and Country Advisory Panels



(CAP). AOSI also intends to continue to meet regularly with senior management from partner organizations to focus on financial, management and coordinating issues, with an emphasis on public relations, dissemination and institutionalization. A Memorandum of Understanding has been developed with input from all partners to establish and clarify operational procedures and policies. Signed by all parties, it clarifies roles and responsibilities, sets out communication mechanisms and procedures, legal and financial issues, grant-making procedures, reporting and monitoring guidelines and programming policies. It is a working document which can be modified as necessary during program development.

AOSI strives to ensure that DDRP activities are conducted in a complementary and synchronized way to enhance and amplify the overall results of

the program. Collaboration is frequent, as described in the program text, particularly when a target population is served by two sub-grantees. The present management structure is designed to facilitate prompt and efficient program implementation as well as to maximize synergies among sub-grantees and sub-sub-grantees through training and information sharing meetings.

Communication strategy

DDRP developed a branding strategy and a marking plan, which both provide a comprehensive framework for communicating the program to the intended audiences.

The branding strategy describes how the program is named and positioned, and how it is promoted and communicated to target groups and host country citizens. It describes the USAID and explains how it will be acknowledged in target countries. The branding strategy consists of intended name of the program; program logo; program communication plan; main program message; conveying the message "From the American People" through public communications; disclaimer; announcing and promoting the program to host citizens in target countries; additional ideas about how to increase awareness that the American people support this program; direct involvement from host-country government organizations; and other groups whose logo or identity is used on communication materials.

DDRP Annual Newsletters, bi-monthly e-Journal News Line and DVD Booklet

The marking plan describes the DDRP public communications, commodities, and program materials that bear the USAID identity.

These two approaches, as a vital part of planning and implementing the program, helped raise the visibility of DDRP in target countries.

Development of models

Under DDRP ten models have been developed, documented and published in English and Russian to assist in their expansion and replication:

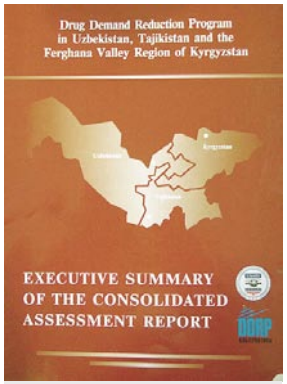
- Drug Demand Reduction Program
- Unique Identifier Code
- "Sister to Sister"
- Treatment Readiness for Drug Users
- Drug free Treatment and Rehabilitation for Drug Users
- Drug free Public Social Spaces
- Drug Demand Reduction Education and Referral of Migrants
- Youth Power Centers
- "Break the Cycle"
- Youth Positive Development

This Model provides an overview of DDRP. It is one of ten Models that have been developed under DDRP for replication and contribution to HIV and drug demand reduction policy and program development in the Central Asian region (see next section).

DDRP Best Practice Collection comprising ten program models

DDRP NEEDS ASSESSMENT AND PROGRAM APPROACH

Increased knowledge about drug use, HIV, and drug demand reduction services in Central Asia



DDRP Consolidated Assessment Report's cover page

A needs assessment with program recommendations for select populations was conducted for DDRP in 2003. The report defined many of the key features of the project and its activities. The assessment noted the need for different approaches for different groups depending on their needs and situations, including: a reduction in demand through prevention and education programs to dissuade users or potential users from experimenting with illegal drugs and/or continuing to use them; drug substitution programs; treatment programs mainly aimed at facilitating abstinence, reduction in frequency and amount of use; court diversion programs offering education or treatment as alternatives to imprisonment; and broad social policies to mitigate factors contributing to drug use such as unemployment, homelessness and truancy.

DDRP would concentrate on specific contexts in which drugs are used, based on a thorough understanding of drug related beliefs, subjective understandings of the efficacy and risks of use of the drug, levels of knowledge, practices, and norms among those who are drug involved. DDRP adapted and developed new models as needed, including adaptation from one context or country to another; adaptation to respond to changes in local conditions in the course of implementation; and adaptation based on problems encountered, lessons learned, and successes.

DDRP would empower the community by involving them in defining their needs and strategies at every stage of program and policy development. Where regions lacked sufficient public health education, clinical, and social service, drug treatment and rehabilitation services, then resource identification and capacity building would be a major facet of programming. Treatment and rehabilitation of drug users were key elements, recognizing that

no single program approach works for everyone, so there would be multiple modalities of treatment adapted to local conditions and circumstances.

The assessment found that drug demand reduction works from a public health perspective—emphasizing risks associated with drug use and ways to reduce them—rather than from a drug control perspective that is essentially punitive in nature. Reliance primarily on information and media campaigns to prevent drug use would be insufficient. The focus had to be on reducing risk factors and strengthening protective factors for drug use. Furthermore the content of information and media campaigns would be carefully scrutinized so that credibility was maintained by: (1) tailoring information to specific population groups to be meaningful; (2) disseminating accurate information to target groups, and; (3) avoiding exaggeration.

It found that effective drug demand reduction involved not only prevention of onset of drug use, but also efforts to reduce drug use across the spectrum. Programs aimed at health promotion, healthy lifestyles, self-esteem building and decision-making in schools would be accompanied by programs aimed at those who were experimenting with drugs, or at drug users who needed various forms of treatment intervention and rehabilitation. Effective drug demand reduction also requires an approach addressing the unfolding nature of addiction (e.g., interventions aimed at averting or disrupting the development of drug dependence) as well as systemic effects (e.g., changing knowledge and attitudes of drug users needed to be paired with accessible services offering alternatives or ways to reduce or eliminate drug use).

A state-of-the-art computerized database and Unique Identifier Code (UIC) system to monitor program activities has been developed to track service utilization and coverage among target groups (see next section and Unique Identifier Code Model). The DDRP UIC is a simple system of anonymous client registration and tracking service usage. It was progressively adopted by all DDRP partners and sub-grantees in Kyrgyzstan, Tajikistan and Uzbekistan. The UIC has also been adopted as the monitoring system of choice by key governmental agencies working on HIV prevention and drug demand reduction in Kyrgyzstan, Uzbekistan, and Tajikistan, and by the USAID-funded Central Asian Program on AIDS Control among Vulnerable Populations (CAPACITY) project, the UK Department for International Development funded Central Asian Regional HIV/AIDS Program (CARHAP),

World Vision programming, some Global Fund projects, and by many local non-government organizations (NGOs) throughout Central Asia.

The DDRP UIC offers significant benefits for both donors and clients. For donors, the UIC provides a robust basis for a monitoring and evaluation framework, providing regular information for management decision-making by monitoring activities and client numbers, as well as evaluating progress towards project objectives. For clients, the UIC allows target group clients to maintain anonymity so they can access essential services such as detoxification, drug dependence treatment and rehabilitation, and HIV prevention services without fear of their risk behavior being disclosed to family, friends, coworkers, or police. The UIC can be used by a group of service providers, creating an opportunity to measure how vulnerable groups utilize multiple services and allowing service providers better opportunities to form links.

Formative research was undertaken with professionals, at-risk youth, injecting drug users, sex workers, prisoners, migrants, vulnerable women and parents to assist in program design and to evaluate suitability of a variety of printed and video resources. Tracking research was done to measure the reach of various education messages and behavior change. Reports from this research were shared between partners and disseminated nationally, regionally and internationally through publications and conference papers.

SELECT POPULATIONS ARE BETTER INFORMED ABOUT HEALTH AND SOCIAL RISKS OF HEROIN/OPIATE USE AND AVAILABILITY OF TREATMENT, REHABILITATION, SOCIAL SERVICES AND ALTERNATIVES

DDRP uses a broad definition of "drug education". Within the Spectrum of Services, education is a core activity in every component. For this reason, drug education is carried out with many different groups in Central Asia.

Youth education

The Youth Power Center program is implemented by DDRP partner PSI at seven sites located on major opiate trafficking routes in Central Asia. The Youth Power Program is implemented in tandem by PSI with the Break the Cycle program to reduce injecting drug user involvement in the initiation of non-users (see the DDRP Break the Cycle Model for more information.)

Youth Power Centers aim to reduce injection drug use among Central Asian youth and so help to avert an emerging HIV epidemic. To accomplish this goal, PSI used research with young people and injecting drug users to identify subgroups of youth who are at highest risk of becoming injecting drug users. The purpose of the Youth Power program is to equip these very high risk youth with the knowledge and skills to make informed, healthy decisions about drug use and sexual behavior. Research has shown that those who socialize with injecting drug users or are exposed to injecting drug use are more likely to inject drugs themselves. Many Central Asian youth between the ages of 15 and 25 are at-risk due to the high prevalence of drug use in the region, a large supply of low-cost drugs, and the overlap between major population centers and drug trafficking hubs.

The Youth Power program separates at-risk youth into three risk categories:

- **Category 1**: Young people regularly socializing with injecting drug users, for example, siblings, partners, friends, or relatives;
- **Category 2**: Troubled youth (i.e. from broken homes, out of school, unemployed, with psychological problems, etc.) living in neighborhoods with high levels of heroin use;
- **Category 3**: Any young person between the ages of 15 and 25 living in neighborhoods where heroin use is common.

The DDRP Youth Power Centers were established along drug trafficking routes in geographic areas that were characterized as "drug using neighborhoods"; parts of cities and provinces with a concentration of drug trafficking, supply, and use. Using qualitative and quantitative research, PSI mapped the factors that influence youth to initiate injecting drug use and combined this with research on drug trafficking routes to ensure each project focused on cities and communities with the highest concentrations of trafficking and injecting drug use. There are currently seven Youth Power Centers operating in the three DDRP target countries: Tashkent, Samarkand, and Termez in Uzbekistan; Dushanbe, Khujand, and Khorugh in Tajikistan; and Osh in Kyrgyzstan, plus two more Youth Power Centers in Almaty, Kazakhstan, and Bishkek, Kyrgyzstan, operating under the USAID-funded Central Asia Program on AIDS Control among Vulnerable Populations (CAPACITY).

Each Youth Power Center serves as a drug-free, safe place where at-risk youth can socialize. Youth Power Centers employ peer educators recruited directly from the target group and trained to provide behavior change communications with at-risk youth to prevent initiation of drug use as well as reduce both drug-related and sexual HIV risk behaviors. Peer education sessions are conducted at Youth Power Centers, local schools and universities and at locations where at-risk youth socialize, such as cafes, bars, discos, parks, resort areas, and on the street. Youth Power Centers also provide healthy, skill-building activities as alternatives to drug use, as many drug using youth cite boredom as a reason for starting drugs. Each Youth Power Center provides a menu of activities based on the target group's interests. These include: sports, games, vocational training, language lessons, and social groups. Peer counseling is provided by peer educators with personal experience of issues related to drug use. Each Youth Power Center also has on staff one or more professional counselors to provide psychological counseling to at-risk youth with emotional, psychological, or other problems.

Central Asia is confronted with twin epidemics of injecting drug use and HIV. Rapid social change has made young people especially vulnerable to injecting drug use and HIV transmitted through risky injecting and sexual behavior. Adolescents and young adults face widespread poverty, unemployment and falling rates of enrollment and completion of secondary schooling. Illicit drug sales flourish in most major cities, making drugs both cheap and accessible. The situation in Central Asia is increasingly being compared to that in the Southeast Asian "Golden Triangle", where HIV epidemics followed drug routes, and infection spread to the general population through sex workers [2].

In 2005, Population Services International (PSI) undertook surveys among young people in Central Asia to find out about the target groups' attitudes toward drug use. In Osh, which is representative of many cities in Central Asia where PSI operates, anasha (cannabis) was found to be the most common drug first used, followed by cigarette smoking and then injecting heroin. Boredom, peer pressure, and raising social status within a group were described as the main reasons for starting drug use. In Osh and across Central Asia, there are many mixed-age informal social groups living in residential areas where there are no recreational facilities. Within these groups the older youths frequently have contact with drugs and crime. In-

dividuals who wish to increase their authority and gain the respect of their peers do so through drinking, crime, and drug use.

The DDRP Youth Positive Development Model (YPDM) is a combination of tools, approaches and strategies designed to enhance the capacity of youth-serving organizations to address issues of drug use, HIV/AIDS and risky behavior over the long term. The Youth Positive Development model was integrated into the activities of youth-serving organizations in 10 cities of Uzbekistan, Tajikistan and Kyrgyzstan, with a special emphasis on networking and knowledge exchange between these organizations. The activities of organizations using the YPDM were geared toward street-active young people between the ages of 12 to 18. The core approach of the YPDM is to generate and sustain the initiative of local organizations, which, depending on certain factors (social, economic and political) and their own organizational abilities, can choose a combination from the wide range of different program elements. DDRP's ongoing working relationships with 13 organizations have helped facilitate the integration and development of the YPDM. Five sites have used the Youth Positive Development model, which showcase a wide spectrum of experiences that can be distilled for further use and development.

This holistic approach of introduction, integration and sustaining of the YPDM can serve as a replicable model of drug use prevention among youth, and as a model for other youth-serving and capacity building programs being implemented in a new country or region.

The YPDM addresses issues that young people have to face in countries of transition of the former Soviet Union, and which are particularly evident in Uzbekistan, Tajikistan, and the Ferghana Valley of Kyrgyzstan, where social and economic challenges are juxtaposed with easy access to heroin and opiates. These issues include:

- The social and economic transition in Central Asia which has led to an increase in risk factors for young people and a growing problem of youth marginalization.
- The youth-serving sector that previously provided services to street-active young people has collapsed, leaving them to deal with multiple and conflicting cultural influences. Youth-oriented programs are not a high priority for governments because of other "larger" issues like general education, health care, unemployment, electricity, water, etc.

- A lack of life and job skills coupled with a non-supportive environment reduces young people's job prospects, leaving them vulnerable to illegal economies and drug use.
- The youth-serving sector needs tools and methodologies for credible drug education and access to social services geared to the needs of youth which can help them reduce the risks associated with heroin / opiate use.
- Youth need encouragement, and in some cases financial aid, to stay enrolled in school.
- All young people need credible role models and access to low-cost or free recreational activities.
- Street-active youth need outreach to link them to vocational training and life skills development, and to provide them with drug use prevention education and exposure to supportive adults who can be role models for them.

The needs assessment highlighted the need for capacity building within organizations working with young people between the ages of 12 to 18 who fit the definition of street-active or non-organized youth (i.e., spending more than 5 hours a day on unstructured and unsupervised activities).

This process had to be focused on equipping institutions and professionals in these countries to address the growing difficulties of youth. Enabling renewal and growth in these organizations and their staff was urgently required if at-risk and marginalized youth were to be genuinely assisted.

To effectively address these needs it was necessary to:

- Develop the professional skills and knowledge of organizations so that they could design their own versions of youth risk prevention interventions in collaboration with young people and local communities;
- Introduce the tools and approaches of the Street Choice program to as many youth workers as possible and encourage them to endorse the suggested methodologies in their work with young people;
- Identify those youth workers and organizations which would be interested in this initiative and ready to develop innovative approaches which would eventually involve other youth workers and youth-serving organizations in order to increase the work's effectiveness;
- Create conditions where people and organizations would be able to recognize and realize their own potential, in turn making it possible for them to recognize and realize young people's potential;

- Provide the organizations implementing the program with a flexible kit of tools and approaches which would most effectively match their needs and abilities.

Community education

An important example of community drug demand reduction education is the DDRP Drug free Spaces projects, five of which were implemented in Tajikistan. These projects were targeted at disadvantaged communities with a high number of migrants to address issues that have exacerbated community disadvantage and driven ever-increasing numbers of people in Central Asia towards crime, including drug-related crime. These issues include:

- Male economic migration to Kazakhstan, Russia and beyond leaving entire communities of female-headed households;
- Concentrations of rural-to-urban migrants on the edges of cities in the cheapest housing, where they become vulnerable to drug use, drug trafficking and HIV infection;
- Language, cultural and other differences, meaning they may not integrate easily into the surrounding community;
- Economic and social pressures contributing to low self-esteem, poor life skills and depression.

Across Central Asia, local community, government and religious leaders are increasingly recognizing the destructive impact of migration and poverty on their societies. The DDRP Drug free Public Social Spaces projects collaborated with communities to address these issues and the complex relationship of vulnerability to drug use and crime. More than 6,000 rural-to-urban migrants live in communities where these projects provide opportunities for alternate activities, healthy lifestyles and discussions on drug related issues (see next section and the Drug free Public Social Spaces Model).

DDRP has implemented five Drug Demand Reduction Education and Referral of Migrants projects, all in Uzbekistan. The migrants projects targeted three groups:

1. Internal economic migrants, or *pereselentsy*, moving from rural-to-urban areas within the same country, as a reaction to poverty and unemployment in villages and former collective farms.
2. Economic migrants leaving *na zarobotki*, or on a short-term or long-term basis to work in another country within the CIS as a result of high unemployment in their country of origin.

3. Refugees from surrounding countries, driven by post-Soviet conflicts and economic uncertainty.

The DDRP Drug Demand Reduction Education and Referral of Migrants projects provided a range of services, including:

- On-site reproductive health and psychological counseling;
- Legal assistance with local registration (*propiska*);
- Legal advice on labor laws and employment contracts;
- Legal advice on passport requirements for work in other countries;
- A hotline to preserve anonymity;
- Drug demand reduction seminars for migrant parents;
- First aid and medical referrals for work related injuries;
- Outreach-based drug education seminars for young males in groups;
- Outreach services for at-risk females delivered through mahalla women's committees; and
- Referrals for no-cost drug treatment or HIV testing (see next section and the Demand Reduction Education and Referral of Migrants Model).

In addition, DDRP implemented nine Sister to Sister projects in Tajikistan and Uzbekistan. These projects were targeted at both rural and urban vulnerable women. Six sites were visited to capture the experience of these projects as they were implemented and evolved. The lessons learned were distilled to produce the DDRP Sister to Sister Model.

The DDRP Sister to Sister projects address issues that have exacerbated female poverty and driven ever-increasing numbers of women in Central Asia toward drug-related crime and sex work. These issues include:

- Male economic migration to Kazakhstan, Russia and beyond leaving women with pressing needs for income but few choices for earning income;
- Increasingly traditional gender roles and expectations, especially in rural areas, again limiting women's ways of earning income;
- Women's diminished access to education, socialization, and employment;
- Economic and social pressures contributing to low self-esteem, poor life skills and depression.

Across Central Asia, local community and religious leaders are increasingly recognizing the negative impact of female poverty on their societies. The DDRP Sister to Sister Model collaborated with communities to address

this poverty and the complex relationship between female poverty and vulnerability to drug use and crime.

Individual projects covered by this model targeted women from their adolescence to middle age. Each of these interventions focused on reducing the economic and emotional vulnerability of women to criminal drug trafficking activities, drug use and sex work. Methods to achieve these results combined drug demand reduction education with a variety of skills training and other activities. There is a referral system for treatment readiness, drug treatment and rehabilitation programs for women drug users and those who are not themselves drug users but live in families where men use drugs (see next section and the Sister to Sister Model).

Education for active drug users

Several major DDRP activities provide education to active drug users, particularly injecting drug users. Activities address injecting drug users in general as well as specific groups of injectors such as sex workers and prisoners. Most education of injecting drug users is combined with motivational interviewing, either for Break the Cycle (BTC) or for treatment readiness. Education programs are based on research about the concerns and education needs of Central Asian drug users.

The BTC Model was designed to help prevent injecting drug users from initiating young people into injecting drug use (IDU). Injecting drug use is a technically complex activity and, without assistance, an individual finds it very difficult or impossible to inject for the first time. In Central Asia, as elsewhere, young people are most frequently initiated into IDU by close friends or siblings who already inject drugs, older and experienced injecting drug users (IDUs), or by spouses. In many cases in the region, it is the non-user who pressures the current user to help him or her initiate. The choice of drug for first injection varies by social network and availability of particular drugs. Young people thus acquire their drug knowledge and make drug-use decisions based on the views of friends, siblings, and personal experiences [3, 4].

The Break the Cycle intervention implemented by PSI in three target sites (Osh, Kyrgyzstan; Tashkent, Uzbekistan; Khujand, Tajikistan) addressed injecting drug use among youth by working with active injecting drug users to discourage them from initiating others into injecting. The theoretical basis of BTC is derived from evidence from many countries that

current injecting drug users play an important role in a young person's decision to try injecting, that many injectors disapprove of initiating others into injecting, and that injectors do not always realize that they may be influencing young people's decisions to initiate injecting.

The DDRP Break the Cycle Model encourages current injecting drug users to modify their own injecting behavior in order to reduce the risk of others initiating injecting. Under the program, **IDUs are encouraged to adopt the following behaviors:**

- Don't inject in the presence of non-injectors;
- Don't talk only about the positive effects of narcotics, i.e. the *kaif*, or high, in front of non-users or non-injectors;
- Don't assist someone with their first injection; and
- Develop skills to refuse unwelcome requests to help someone learn to inject.

Interventions with IDUs typically use either outreach models, with the outreach worker as the expert informing the target group, or peer education in which the information is transferred by peers who should be practicing less risky behaviors. To promote BTC target behaviors, outreach workers change the outreach worker-drug user dynamic so that rather than the outreach worker operating in a superior position informing the drug user, the drug user is in the dominant position being asked questions by the outreach worker using a technique called "motivational interviewing."

Using motivational interviewing, BTC outreach workers use open-ended questions to evoke revelations from the target group. Outreach workers interview drug users about their own injecting initiation and other injecting experiences in order to encourage thinking about the role that they, possibly inadvertently, may be having in increasing the chance that non-injectors around them might initiate injecting. These conversations also build the refusal skills of drug users who are often approached by non-injectors with unwelcome requests to help with injecting.

Break the Cycle was implemented by PSI as part of their overall strategy aimed at drug demand reduction among youth in Central Asia region. The major innovation of the model is the revelation that, in order to effectively reduce youth initiation of heroin use and injecting, programs must both educate youth at high risk of initiating injecting on the risks of IDU and,

simultaneously, encourage IDUs who typically play a role in youth initiation not to help non-injectors initiate injecting.

DDR and health education for sex workers

The DDR-SW program operates in three sites in Central Asia targeting sex workers, drug using sex workers (referred hereafter as DU-SWs), and drug users who sell sex. These three sites (Osh, Kyrgyzstan; Tashkent, Uzbekistan; and Khujand, Tajikistan) were selected because of the high prevalence of drug use (in particular injecting drug use) and sex work, the high prevalence of HIV and Hepatitis C among IDUs, and the resulting high vulnerability of SWs to drug use and Hepatitis and HIV transmission in those sites.

The program uses outreach teams to provide field visits and educational sessions to increase the awareness of sex workers about risks of heroin/opiate use and improve their awareness and utilization of drug demand reduction services. Outreach education is one of DDRP's key tools to ensure SWs in target sites are better informed about the health and social risks of heroin/opiate use, the dangers of risky sexual behavior, and availability of treatment, rehabilitation, and other health and social services. The work with DU-SWs focuses on building their awareness of the risks related to their current drug use and their awareness of DDR services in their district. The work with non-DU-SWs focuses on building their understanding of topics such as addiction and other drug risks that will reduce the chance of their initiating drug use.

DDR and health education for prisoners

At the initial stage of program implementation, DDRP was allowed by penal system authorities to implement direct education activities with inmates and prison staff in select prisons using two approaches: (1) information sessions for the general inmate populations and (2) targeted interactive trainings. The expected outcome of the education system is to increase the level of knowledge and improve attitudes of inmates towards DDR and health-related issues through trainings and information sessions while setting up a sustainable, continuous, and institutionalized DDR and health education system in prison.

Public awareness campaign and IEC materials

In close collaboration with national counterparts, DDRP has been extensively involved in supporting IEC and public awareness campaigns in target countries to bring the attention of select populations and civil society to drug use and HIV/AIDS issues. Through various public information events, poster contests, quiz and Q&A sessions, and sports activities, the campaign helped raise awareness among select populations about the health and social risks of drug use, healthy lifestyles and the availability of quality DDR services on the ground. The media campaign, including national contests for the best media products, also complemented the overall efforts by increasing public awareness of program activities and raising the the program's visibility among intended beneficiaries.

DDRP IEC materials comprise a wide range of education, media, and promotional materials to address DDR and HIV/AIDS prevention issues among various population groups and promote the program among intended audiences. The program facilitated full involvement of the target groups, including at-risk populations, in the production and dissemination of all materials.

In addition, a Migrants' Guide was produced and published in Tajikistan, and was disseminated among labor migrants. The documentary "A Fine Line", aimed at familiarizing a general audience with drug use and HIV/AIDS issues, was produced in Uzbekistan. Booklets and brochures were produced for prisoners and sex workers to help them consider drug treatment and to provide education on the consequences of drug use, including HIV infection.

INCREASED AVAILABILITY OF UNIVERSAL, SELECTIVE AND INDICATIVE LEVELS OF DRUG DEMAND REDUCTION SERVICES AND ACTIVITIES CHARACTERIZED BY BEST AND MOST UP-TO-DATE PRACTICES

More than 60 grants were awarded to NGOs and government organizations in Uzbekistan, Tajikistan, and Kyrgyzstan in the period of 2004-2007 to implement DDRP projects.

DDRP implemented ten treatment readiness projects in Kyrgyzstan, Tajikistan and Uzbekistan. These projects were targeted at drug users, including sex working drug users and active injecting drug using youth. The DDRP treatment readiness projects aimed to decrease injecting drug use and HIV transmission

by motivating active injecting drug users to undertake treatment and to stop using drugs. The treatment readiness projects worked closely with the DDRP Drug free treatment and rehabilitation projects. (The Drug free Treatment and Rehabilitation Model is another publication in this series).

Central to reducing the demand for drugs is the motivation of drug users to undertake treatment. However, individuals are often ambivalent about ceasing drug use. The first stage of treatment readiness thus involves the assessment of an individual's preparedness to change. Through repeated contacts, individuals move towards a decision to stop drug use and seek treatment.

A range of approaches characterized the various DDRP treatment readiness projects. Common to all projects was a client-centered approach, based on reinforcing the client's psychological strengths. This approach encouraged clients to develop an individual path out of drug use. Projects thus aimed to create a positive environment in which changes aimed at abstinence from drug use could be initiated and supported. Motivational interviewing was the main technique used to assist client decision making. Services to the target group were provided by counselors appropriately trained in drug dependency. Treatment readiness services were provided both through outreach and at fixed sites alongside other services to IDUs. All steps on the path from drug use to abstinence were regarded as indicators of success both for individual clients and for the project. The following were examples of client progress towards abstinence:

- A reduction in daily dosage of drugs;
- A reduction in frequency of drug use;
- Regular participation in the DDRP treatment readiness activities; and
- Referral to the DDRP Drug free treatment and rehabilitation program.

The approaches described later in the document show the range of services used in the DDRP Treatment Readiness for Drug Users Model. The provision of additional services depends on the resources available to an organization, and these services should not interfere with the client-centered approach of this DDRP model. The 12-step program is one example of an additional service that can successfully complement the treatment readiness approach.

Individuals seek treatment for a range of reasons. However, barriers to treatment include financial constraints, fear of registration as a drug user, and perceived low efficacy of available treatment services [5]. DDRP offered

integration of treatment readiness with free, anonymous and evidence-based treatment services to injecting drug users in an effort to minimize the barriers to their entering treatment and stopping drug use.

DDRP implemented ten Drug free treatment and rehabilitation projects in Kyrgyzstan, Tajikistan and Uzbekistan, which were targeted at dependent heroin/opiates injectors who had made a decision to stop using drugs and turned for help to the DDRP Drug free treatment and rehabilitation program.

Clients could self-refer to the project for the following assistance:

- To cease drug use;
- To reduce the symptoms associated with withdrawal;
- To remain drug free after a course of pharmacologically-assisted detoxification.

If a client ceases drug use after entering the Drug free treatment and rehabilitation program, the program offers relief from withdrawal symptoms in the form of auricular acupuncture as per the U.S. National Acupuncture Detoxification Association (NADA) guidelines. In addition, relaxation assistance includes phytotherapy (traditional herbal medicine), natural hot water springs, specialist dependency counseling, and the support of peers taking the course of inpatient rehabilitation. Where the projects are located within a medical facility, pharmacological detoxification may be offered. The provision of the services depends on the resources available to the individual organization delivering the Drug free treatment and rehabilitation program.

Treatment and rehabilitation services include psychological assistance and psychotherapy aimed at enhancing individual patients' ability to overcome their drug dependency and develop work skills through occupational therapy in the form of physical labor. In many projects, the 12-step approach is used, most commonly in the format used by Narcotics Anonymous (NA), with counselors acting as the core of the program.

There were two main features of the Drug free treatment and rehabilitation approach in all projects:

- A therapeutic environment, characterized by positive, supportive, non-stigmatizing staff attitudes towards patients, and strong peer support among patients undergoing the course of rehabilitation.
- The support of specialist dependency counselors dedicated to the development and fulfillment of individual behavior change plans. In addi-

tion, counselors also helped to strengthen individuals' commitments to adhere to their plans.

Thus, Drug free treatment and rehabilitation programs provide distinct phases of holistic and culturally appropriate care to address the bio-psycho-social aspects of heroin/opiate dependence. Treatment components may include: medically and psychologically supervised detoxification within the context of peer-based support; a strengths-based approach to treatment where the social environment encourages personal growth and development; daily psychological group work that provides the drug dependent individual with the opportunity to learn about and reflect on the bio-psycho-social nature of his/her addiction and its management. Adjuncts to treatment may include: talks by former drug users, 12-step meetings, life skills development, creative activities, exercise, stress reduction, yoga, ego strengthening, and self-regulation as well as peer community work and drug-free social and recreational activities. As part of comprehensive treatment and rehabilitation, crisis intervention, culturally appropriate support, education, and therapy should be available and accessible to address drug-related problems and to foster and rebuild family relationships, thus paving the way for the recovering individual's reintegration into family and community.

A comprehensive and effective approach to treatment recognizes the complex and often chronic nature of heroin/opiate dependence and provides treatment plans created in collaboration with individual clients, allowing them to set realistic goals for change and move at their own pace. Phases of treatment may include:

- Early counseling and assessment where treatment strategies are appropriately matched to the stages of readiness for change;
- An intensive phase of detoxification and treatment, where peer oriented support, professional help, and psychological counseling, and related activities form a collective "scaffolding" around the individual in the early stages of personal growth and development and reliance on mutual help as an alternative to heroin/opiate use;
- A second phase, once early recovery is underway, can focus on integration into autonomous networks of mutual help, the development of knowledge, skills and capacity for relapse prevention, vocational training, life skills development, and reintegration into family and community. Tracks of treatment and rehabilitation can be targeted to the needs of select populations: youth, street involved youth, women with dependents, husbands and fathers, sex workers, and people living with HIV.
- These initial phases of residential treatment and rehabilitation can be followed by a 'stepped down' approach where longer-term rehabilitation options are matched to individual needs. Options in this phase can include out-patient treatment components, volunteer opportunities within the treatment context, job training activities, regular participation in autonomous 12-step networks, or, longer-term residency in a half-way house, which is a self-sustaining, drug-free peer driven community setting. In this phase, the focus is on relapse prevention and support to live free of heroin/opiate dependence through informal mutual support networks, vocational training, education, and life skills development appropriate to the select population.

STRENGTHENED CAPACITIES OF COUNTRIES, REGIONS, AND COMMUNITIES TO PREVENT AND ADDRESS HEROIN/OPIATE USE

DDRP held skills building trainings in the three target countries, at which various professional and paraprofessional groups have been trained (including drug treatment specialists, psychologists, researchers, outreach workers, and counselors). IEC and support materials were also produced and disseminated among these groups to increase their capacities in the working with vulnerable populations.

DDRP provided professional trainings for medical and non-medical prison staff and inmates, developed training and information materials and provided national penal systems with emergency supplies. The expected outcome of these trainings is to increase the capability of prisons' medical and non-medical personnel to prevent and address heroin/opiate use within prison settings by enhancing knowledge and skills of professionals. Follow-up for participating medical staff was organized two to three month after the training.

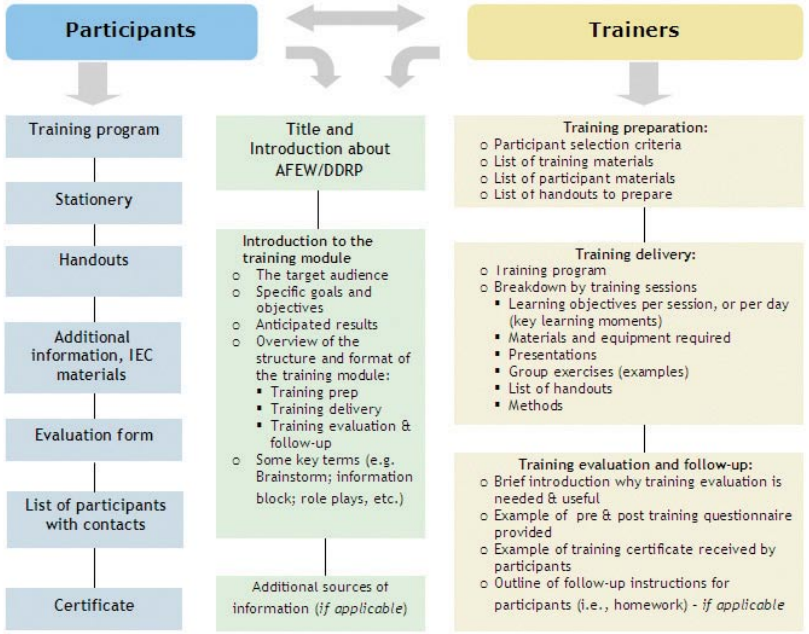
Substantial work was carried out to enhance the environment in which drug demand reduction and HIV prevention services are delivered to sex workers. To build professional capacity of local partners and provide drug demand reduction and HIV prevention services to sex workers, DDRP conducted capacity building trainings in three program countries; DDRP sum-

marized training materials in comprehensive training modules which were used to support DDRP outreach programs in increasing the use of drug demand reduction, HIV and other social and health care services.

Three training modules on consulting in DDR context and consequences of drug use were produced for medical and non-medical prison staff and for inmates. Five training modules on organization of work and education sessions for law-enforcement staff, outreach work and services for sex-workers and motivational interviewing were produced targeting governmental, non governmental organizations and police staff on DDR and health promotion services delivery among sex workers.

Trainings were provided to media specialists on DDR and HIV prevention. Three manuals on partnerships with mass media, TV and radio social

Graphic Overview of the Training Modules



programming, and production of documentaries were produced in Tajikistan. These manuals contributed considerably to the increased coverage of drug use issues and social messages by media outlets and improved collaborative relationships with NGOs.

All local partners received ongoing trainings on effective NGO management in strategic planning, human resource development, fund-raising, planning, community involvement, financial management, and local model development. Regular consultancy visits helped local partners improve existing practices and supported networking between them.

DDRP Resource Centers were launched in Tajikistan and Uzbekistan, where various professionals can access up-to-date information on public health, DDR issues, drug prevention, and HIV/AIDS.

Helping governmental and non-governmental organizations improve how they work on DDR and HIV issues with vulnerable groups is a very important contribution of the DDRP program in Central Asia. DDRP's work on M&E systems has greatly improved the ability of each target country, and organizations working in those countries, to track progress towards reaching high coverage of key risk groups. Having these M&E systems, in particular database programs to track client contacts, has also enabled DDR and HIV programs to make anonymous services more accessible to key target groups in need of DDR and HIV services.

DDRP supported the pilot implementation of the DDRP Unique Identifier Code at the national level by four healthcare services of Tajikistan: drug treatment, HIV/AIDS, STI, and TB. The proposed DDRP coding system to reach high coverage among target groups an easy-to-use tool for statistics and M&E purposes. The UIC will be used as part of M&E to track national indicators established by the Country Coordination Mechanism on AIDS, TB and Malaria. DDRP assistance included development and adaptation of the UIC database program (including data entry cards) for target groups; procurement of required computer equipment; delivery of trainings on the use of the UIC system to national and local staff; and monitoring trips for situation analysis and feedback by staff from the Ministry of Health. Implementation of the Unique Identifier Code and Unified Monitoring and Evaluation systems will help create a mechanism to provide anonymous medical and social services to, and effective referral system for, drug users.

IMPROVED REGULATORY AND POLICY ENVIRONMENT RELATED TO DRUG DEMAND REDUCTION

Amendments proposed by DDRP experts were incorporated into the Law on Drug Treatment Care adopted by the Tajik Parliament in 2003. Technical assistance and international expertise were provided to the Drug Control Agency of Kyrgyzstan to reform existing legislation on drug-related crime and develop a new law on drug abuse prevention activities.

DDRP has established and supported national working groups on health promotion in prisons in three project countries, institutionalized these coordination mechanisms and incorporated training curricula into official systems of professional development for prison staff, which have been accepted as a national standard for training prison staff on HIV prevention.

A drug use prevention curriculum for vocational schools including a manual for teachers and textbook for students was developed, published and introduced in all vocational schools in Tajikistan. A new special subject – the Street Business Toolkit – began in the vocational school system in Tajikistan and became DDRP's second addition to the state curriculum. The drug use prevention curriculum for secondary schools including a manual for teachers was developed, published and delivered to the Ministry of Public Education for introduction in the school system in Uzbekistan.

DDRP PUBLICATIONS

MANUALS
- Drug Use Prevention Manual for teachers & Drug Use Prevention Textbook for vocational school students
- Youth Business Manual for vocational schools
- Drug Use Prevention Manual for secondary school teachers
- How to Work with Mass Media for NGOs
- Socially important TV & Radio Broadcasting
- Production of Documentaries
- Street Choice Program
- Street Business Toolkit Program

GUIDE-BOOKS
- Peer Education guide
- Outreach Work among Youth
- Acupuncture for Drug Treatment Specialists
- Motivational Interviewing of Injecting Drug Users for outreach workers
- Migrants guide
- Recourse guide for drug counselors

PROTOCOLS
- Treatment Readiness
- Drug free Treatment & Rehabilitation

TRAINING MODULES ON DDR IN THE PENAL SYSTEM
- Consulting in DDR Context for medical prison staff
- Consequences of Drug Use for non-medical prison staff
- Consequences of Drug Use for inmates

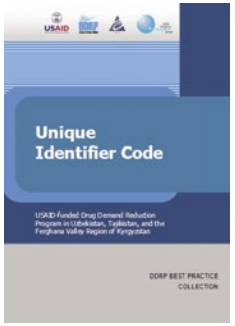
TRAINING MODULES
- Organization of services for sex workers for GOs and NGOs
- Organization of work with law enforcement staff for GOs and NGOs
- Outreach work among sex workers for GOs and NGOs
- Motivational Interviewing for GOs and NGOs
- Series of education sessions for law enforcement staff on DDR, HIV/AIDS prevention and health promotion issues

DDRP BEST PRACTICE COLLECTION (please see page 8)

BENEFITS OF EACH DDRP MODEL

UNIQUE IDENTIFIER CODE (UIC)

The UIC is easy to remember



The information used to produce each individual's DDRP UIC is easy for the individual receiving services to recall when the outreach worker or service provider asks the prompt question, and it remains constant, no matter which outreach worker has contact with the client.

This UIC is therefore superior to other codes in use in the region and elsewhere. In these other systems, outreach workers assign codes to the target group. Unlike those systems, the UIC contains no identifying information about name, date of birth or place of residence.

The UIC meets the needs of donors and clients

The DDRP UIC offers significant benefits for both donors and clients. For donors, the UIC provides a robust basis for a monitoring and evaluation framework, providing regular information for management decision-making by monitoring activities and client numbers, as well as evaluating progress towards project objectives. For clients, the UIC allows target group clients to maintain anonymity so they can access essential services such as detoxification, drug dependence treatment and rehabilitation, and HIV prevention services without fear of their risk behavior being disclosed to family, friends, coworkers, or police. The UIC can be used by a group of service providers, making it possible to measure how vulnerable groups utilize multiple services and allowing service providers better opportunities to form links.

The UIC addresses target group coverage and universal access

The DDRP UIC Model is one of the basic elements of a spectrum of services approach. The spectrum of services incorporates drug demand, risk reduction, and HIV prevention into a unified approach that can be implemented within a defined region. The spectrum of services approach is based on the principle that drug demand reduction, risk behavior reduction and HIV prevention behavior change result from target group members using multiple agencies. Once these agencies are linked through the UIC-based system of active cross-referral, individuals needing assistance will have both greater access and choice. In a fully implemented spectrum of services, drug users, youth at-risk of initiating injecting drugs or sex workers can enter the spectrum at any point, obtain appropriate services, and then be assisted by program staff to move to other appropriate programs. For further information, please refer to the spectrum of services diagram in the Appendix.

The spectrum of services aims to reach 100% of injecting drug users and sex workers with at least one component on a regular basis. Implementers use UIC-based databases as a monitoring and evaluation instrument to show the percentage of target clients reached by a service provider within a defined region over a defined timeframe. The UIC provides information that program decision makers can act and assists them in modifying programs in response to emerging needs.

DDRP projects demonstrate the effectiveness of outreach in providing clients with education, advice and referrals aimed at changing their risk behavior [18]. In developing and transitional countries, drug demand reduction services are generally poorly coordinated. The spectrum of services, when combined with the UIC, can improve the integration of local government and non-governmental health services.

The quality of drug demand reduction services for anonymous UIC-registered clients is progressively improved as an increasing range of organizations adopt the UIC. Further, once the monitoring systems of geographically proximate service providers are linked, the UIC allows evaluation of broader trends in the pathways of service utilization. This in turn promotes and further increases in referrals between participating service providers. The UIC is both a tangible and significant step towards universal drug demand reduction and HIV prevention access.

The UIC provides managers with tools for program planning

The DDRP UIC system enables programs with a gradualist approach to track target groups. Gradualism is an approach to drug demand reduction that helps individuals to move from active drug use toward moderation

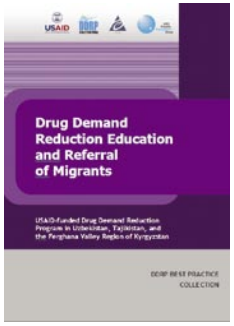
or abstinence [6]. As use of the UIC evolves, it will increasingly link service providers, allowing program implementers and researchers to track and actively manage service utilization trends. Clients registered with the UIC can move from unstructured services such as drop-in centers providing treatment readiness, to detoxification, drug dependence treatment and rehabilitation services as required. In addition to monitoring progress, the UIC will allow analysis of relapse trends, which are an unfortunately common step on the path of dependence treatment and rehabilitation. This treatment and relapse data will thus allow direct comparison of the quality of different drug demand reduction services and the quality of referrals made, and it will help identify barriers to achieving optimal effectiveness.

The UIC's active feedback monitors short-term progress towards longer-term goals. Decreasing injecting drug use and HIV transmission requires a long-term investment in behavior change and service provision. This requires active monitoring of short-term performance to on the pass towards achieving longer-term goals. When combined with behavioral surveys, program managers can act on the feedback provided from the UIC-based monitoring system to rapidly remedy programmatic weaknesses and motivate staff to optimize intervention effectiveness.

The anonymity of the DDRP UIC underpins advocacy. Protection of human rights is central to the way the UIC is used by DDRP partners and others. The UIC provides government service providers with a superior alternative for the management of confidential personal information. It provides managers in the government sector with an instrument that is easy to remember, meets client demands for confidentiality, and enhances government data collection and surveillance capacity. Confidentiality is essential for effective implementation of interventions among at-risk groups. Anonymous service provision is linked to higher rates of drug demand reduction and HIV testing services [7].

DRUG DEMAND REDUCTION EDUCATION AND REFERRAL OF MIGRANTS

Targeting migrants reaches marginalized populations



Each of the projects reviewed developed practical and innovative approaches to working with hard-to-reach migrant communities. The legal status of many migrants is uncertain, meaning many are not eligible for health, education and welfare services and may wish to avoid close scrutiny. Outreach work proved particularly valuable in reaching marginalized migrant populations at-risk of involvement with drug use and drug related crime. Migration has for many resulted in chronic poverty and social isolation. This has been exacerbated by host country regulations limiting migrants' rights to residency, employment, medical care and social services. Faced with these burdens, many migrants live for years at-risk of involvement in drug use, sex work and disease.

Innovative outreach approaches have proved to be the most effective means of reaching these partially hidden migrant populations. Outreach is an effective strategy for connecting with hard-to-reach, hidden populations of at-risk individuals and injecting drug users (IDUs). In studies of injecting drug users, a significant proportion of IDUs receiving outreach based interventions reduced their risk behaviors around drug use and sex and increased their protective behaviors [8]. For example, the NGO Mekhri in Tashkent targeted the streets where casual laborers gathered across the city before dawn each morning and offered a broad range of drug demand reduction and health related activities.

DDRP projects have highlighted the relationship between drug use and migration in Uzbekistan and Tajikistan

The Drug Demand Reduction Education and Referral of Migrants Model has been the catalyst for a more open debate about migration-associated social dislocation in Uzbekistan and Tajikistan. Migration has been driven by conflict, rural poverty and large populations of young, unskilled people. Whether it is the arrival of refugees from surrounding countries, rural-to-urban migration, or the mass economic exodus of males to work in Russia,

social dislocation has created the preconditions for an injecting drug use epidemic and drug-related crime. The far-reaching social implications of this phenomenon are now being recognized by donors.

Education needs to be credible to target groups if messages are to be effective. The problems created by male economic migration resonated strongly with elected officials, community leaders and men and women across the region, and provided a credible context for all interventions. In the migrants projects, each funded organization sought to identify issues of local importance and developed a unique response to reach the local marginalized migrant population.

While migration was a particular focus of the migrants' projects, it was also an important and recurring issue through all DDRP projects. As such, this Model is much more than the documentation of a series of projects – it is an example of donor support for innovative local responses to a genuine social crisis in Uzbekistan and Tajikistan.

Projects led to significant benefits for individuals

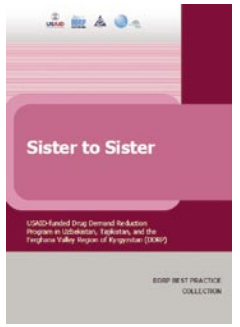
Each of the migrant projects focused on reducing the demand for drugs among migrants in Uzbekistan and Tajikistan. The broad range of groups to which the title migrant might be applied meant that a broad range of individuals benefited from DDRP interventions. For example, the Ferghana Branch of the Uzbekistan Association for Reproductive Health (UARH) targeted female migrants for assistance with obtaining residency permits, and the Samarkand UARH targeted sex worker and drug user migrants. By contrast, Mekhri in Tashkent targeted young males and provided them with emotional support and advice on employment contracts and work safety, while the other project in the same city targeted the entire Afghan diaspora through children's education.

SISTER TO SISTER

Sister to Sister is an appropriate approach to reach its target population

In some target provinces, there were doubts as to whether projects could reach women and girls with education and activities, as strict traditional approaches to child-raising and women's roles might prevent their involvement. However, through careful advocacy and explanation with

local authorities, and by tailoring skills-building and other activities to fit local conditions, projects were able to reach substantial numbers of women and girls. The project in Istaravshan city in Tajikistan, initially planned to attract 30 female students to its drug demand reduction activities but double this number were ultimately recruited.



Credible, relevant education and information is the backbone of an effective response to preventing drug use and related harms. Education needs to be credible to the target groups if messages are to be effective. Each Sister to Sister project sought to identify issues of importance to women as well as local community leaders. The problems created by male economic migration resonated strongly with community leaders and women across the region and provided a credible context for all interventions.

Projects led to greater recognition of women's and girls' vulnerability to drug use and crime

It has been found in many contexts that women are less likely to discuss personal or family drug use, and less likely to seek specific assistance for these issues than men [9]. This leads to a lack of visibility of the problems faced by women and girls related to drug use and crime. Through advocacy and explanation, several projects have raised the visibility of these issues at the local level.

Sister to Sister led to significant benefits for individuals

Profound changes in self-esteem, appearance and communication style were noted at a number of projects following relatively short interventions at low cost. One graduate from the first Tadbirkor Ayol project in Samarkand, Uzbekistan, successfully applied for funding for an entrepreneurial interest-free loan. With this assistance she purchased commercial cooking equipment and started her own small business. Changing attitudes toward female education and employment were observed in Sheykhak village. Local parents are increasingly responding to pressure from daughters to allow them to complete school, and local families have noted that women are able to feed their families and help their relatives.

Projects led to further ideas for promoting business and other opportunities

Sister to Sister projects led non-governmental organizations (NGOs) and other agencies to identify further business opportunities appropriate to the region. These opportunities ranged from vegetable greenhouses in Samarkand (Uzbekistan) and plans to provide on-site education for vulnerable women at a communal housing project in Khujand (Tajikistan) to a dedicated retail outlet in Dushanbe (Tajikistan). Provision of commercial courses alongside non-commercial courses was seen as offering greater scope of sustainability in Chirchik (Uzbekistan): computing and professional food service courses are two such opportunities. Several commercial organizations have been approached to sponsor further training and new opportunities.

DRUG FREE PUBLIC SOCIAL SPACES

Drug free spaces led to significant benefits for individuals

Drug free space is a space where children can play with children and where adults and extended kinship networks can gather and interact. In the face of many changes, the process of creating, participating, and maintaining a public space provides migrant families much needed "social capital" that builds stronger families, more closely knit networks of families, and more neighborliness and social governance. The creation of this Drug free space serves as a platform for drug education. Through this phased intervention, a targeted group of adults, parents, migrant families, and mahallas, rather than being treated as fragmented populations needing separate or distinct interventions, are directly involved and collectively empowered to create a community level response to reducing drug demand.

The DDRP Drug free Public Social Spaces projects facilitated social contact among recent arrivals and their more established neighbors in a friendly atmosphere that combined social activities with drug demand reduction education. Each of these interventions focused on reducing the economic and emotional vulnerability of children, adolescents and parents to criminal activities including drug use. The Drug free spaces projects aimed to create a common "Drug free social space", which allowed local people to socialize, and combined drug demand reduction education with a variety of skills training and other activities.

Focus on migration related issues

The Drug free spaces projects focused on migration: one of the most important and unrecognized influences on HIV and drug use risk. Rural-to-urban, cross-border, and male migration to Russia have disrupted once-strong traditional social structures across the region. The Drug free spaces focused on female-headed rural-to-urban migrant households, including at-risk adolescents in these families. One of the Drug free spaces projects was also able to access students who were considering travel to Russia as illegal economic laborers, providing them with drug demand reduction and HIV prevention information.

Unique access to difficult-to-reach vulnerable populations

Female-headed households and their children were frequently socially isolated from their neighbors, making them difficult to reach. This manifested in a lack of socializing between both adults and youth. In most sites, the children of newly arrived migrants exhibited poor school attendance and frequently fought with longer-term residents. Before the Drug free public social spaces projects, both young people and families were effectively excluded from their local neighborhoods, and inaccessible for other interventions. The DDRP projects provided access to these vulnerable populations, and identified and addressed many of the most urgent issues facing these groups.

Each project sought initially to open a dialogue between newly arrived and longer term residents. In each case the creation of a Drug free social space was a tangible and achievable goal that required community cooperation to complete. The completion of the project also required discussion of social problems such as drug use and created social mixing aimed at building social capital.

Visible improvements to community infrastructure

The Drug free spaces projects provided visible improvements to community infrastructure. In Chkalov and Dushanbe, particular care was taken to ensure appropriate recreational equipment was constructed for children and adolescents. Children could make use of swings and playground equipment, while adolescents could make use of basketball courts. In each case, tables and park benches for adult socialization complemented recreational equipment. The projects thus provided equipment for all ages. In Dushanbe, the drug free spaces projects stimulated residents of surrounding apartments to clean and paint their buildings and to take greater pride in their neighborhood.

Catalysts for sustainable community activities

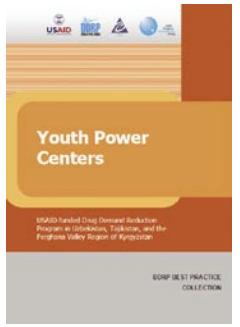
The Drug free spaces projects provided a focus for ongoing cooperation, as each outdoor recreational facility requires regular maintenance. In Dushanbe, the project restored a community hall as well as an outdoor recreational area, providing a space where, as in a rural area, many families might gather together or celebrate significant events. In Chkalov, the Drug free spaces project became the site for ongoing sports competitions. In Dushanbe, the National Taekwondo Federation undertook two projects in response to youth social problems and drug use. The Drug free spaces projects created interest from commercial sponsors and from government officials. In each instance, the Drug free spaces projects demonstrated that an innovative approach to drug demand reduction can catalyze further community action.

YOUTH POWER CENTERS

Youth Power projects target young people at greatest risk of injecting

DDRP/PSI Youth Power Centers were established in low income areas in cities located along major drug trafficking routes. Youth Power Center services were extensively promoted to the target group in the neighborhood around each center through outreach, word of mouth, seminars, public events and mass media. Young people coming to the Youth Power Centers to access recreational and educational activities were encouraged

to participate in a set of fun, interactive peer education sessions on HIV, sexually transmitted infections, heroin and drug use prevention, and other topics to help build their skills to protect themselves from HIV. The education they gained through these sessions was reinforced during Youth Power recreational activities and through random surveys to test their knowledge. In addition, trainers and peer educators identified at-risk individuals through surveys and group discussions to determine their exposure to drugs. Those individuals who were found to be regularly socializing with people who inject drugs were identified as most at-risk of initiating injecting. They were, therefore, given special attention by Youth Power Center staff and volunteers, who made a special effort to keep them engaged in the program in order to reduce their chances of initiating high risk behaviors such as injecting drugs.



Pragmatic strategies to achieve goals

PSI uses qualitative and quantitative research to determine the factors that influence youth to use and especially to inject drugs. PSI also monitors changes in drug trafficking routes in order to ensure that the program maintains its focus on cities and communities with a high concentration of trafficking and injecting drug use. Support and counseling is provided by peer educators with relevant personal experience and is based on trust that has been built between peer educators and the target population. Each Youth Power Center operates as part of the neighborhood. Youth Power staff, peer educators, and volunteers are community-based agents working with community organizations and families as well as vulnerable youth. Youth Power Centers provide opportunities to at-risk youth to bolster their sense of self-worth, and healthy alternatives to drug use such as language lessons, computer training, sports, dance lessons and movie nights. In addition, PSI has demonstrated the effectiveness of outreach in providing youth with education and advice aimed at changing their risk behaviors.

Young people were involved in planning and program implementation [10]

Training of volunteers of the same age as the target group was integral to the success of the Youth Power projects. Volunteers received initial and ongoing training in the principles associated with drug demand reduction. Volunteers were also invited to nominate relevant topics of interest for training sessions. Regular PSI in-house training sessions included education on HIV, outreach, communication skills, gender issues, and drug dependence. Most peer-to-peer volunteers were university students and reported professional development benefits including group facilitation, leadership and communication skills associated with their involvement with PSI Youth Power Centers. Trainers were selected from among volunteers for additional training of trainers (TOTs) sessions.

Youth Power Centers are a familiar model of structured youth leisure time

The support of local government decision makers for drug demand reduction interventions is crucial. Programs should offer a balanced approach, including provision of HIV prevention and drug demand reduction services for vulnerable groups [11]. DDRP in Central Asia has filled an important gap by providing such DDR programs to supplement the extensive HIV prevention programs operating in the region. The governments of the region have welcomed this approach and have strongly supported DDRP's provision of much-needed leisure-based interventions with positive youth peer role models, as with the Youth Power Center program.

Suite of services

Because DDRP has implemented Youth Power services together with a suite of other services, there has been a significant enhancement of linkages across youth drug use and HIV prevention services in the sites where PSI projects are operating. This is most evident in the synergies between the Youth Power and Break the Cycle projects. Many conventional forms of drug demand reduction – drug education and prevention activities – assist young non-injectors to understand the risks attached to drug use and, in the case of DDRP in Central Asia, to heroin injecting in particular. With the addition of Break the Cycle projects, prevention efforts address non-injectors through various interpersonal and other communications activities, but also through programs targeting the active injecting drug users who may play a role in initiating at-risk youth to begin injecting.

Together, PSI's services form an overall strategy to prevent both drug injecting and the transmission of HIV/AIDS in Central Asia, in which all elements are working with sufficiently high numbers of each target population in each target site to achieve effectiveness. There is now evidence from developed, developing and transitional countries that a sufficiently high coverage of specific activities and services can prevent, control or reduce a HIV epidemic. Youth Power is a prime example of a high impact, high coverage model for drug use and HIV prevention.

These services are tied together and linked to other DDRP projects and other programs tackling drugs and HIV/AIDS in Central Asia through use of the Unique Identifier Code (UIC). The UIC was developed as part of the monitoring and evaluation framework for Youth Power Centers and is now in widespread use in the region, allowing different programs to track their own coverage levels and also to see the flow of clientele from one program to another. (See the Unique Identifier Code Model for further information).

Giving youth a voice

In most parts of Central Asia, authority tends to be vested in age and there is a strong culture of younger people respecting and listening to their elders. In a rapidly changing situation like the current HIV and drug use epidemics, this can be a hindrance to discussions about ways to address these issues, as older people have little experience or knowledge in these areas. Through Youth Power Centers, Central Asian youth are finding safe ways to respectfully engage in dialogue with older members of society about their needs and aspirations. This was demonstrated most forcefully in the play "On Heroin", developed and performed by Youth Power Center clients in Tashkent, based on real-life stories related to drug use and HIV, and subsequently presented to audiences in several cities.

YOUTH POSITIVE DEVELOPMENT [12]

The Youth Positive Development model creates a social partnership within the youth-serving sector and allows for cross-sectoral collaboration

Starting with external training for youth workers, the Youth Positive Development Model encouraged governmental and non-governmental organizations to collaborate in order to make drug use prevention more effective. DDRP's approach in these cases was not to work directly with the authorities, but rather to facilitate the local partners' initiative. The government's in-kind support (such as providing a building for youth work in Varzob, Isfara, and Khujand), and their cooperation in planning and implementing drug use prevention activities were the result of direct communications between government institutions and local partners.

The Youth Positive Development model led to significant organizational capacity building

The organizations involved in the Youth Positive Development model have developed significantly over time. Each of them now has a sustainable and well-trained staff, strong links with local community members and local authorities, and many of them have received a space for work as in-kind long-term support from local government structures. Besides DDRP support, each of the partners has attracted other funds for the implementation of the Youth Positive Development model. Each local partner also plays the role of capacity building agent for programs and organizations in their cities and oblasts.

The Youth Positive Development model has led to significant changes in young people's self esteem, attitudes and behaviors

75% of parents and teachers of the Street Business Toolkit (SBTK) program participants reported positive changes in young people's attitudes about schooling. Local partners reported cases in which young people returned to school after completing SBTK courses. Young people working on the street were motivated to finish their secondary education, and many of the Street Business Toolkit participants who started or improved their businesses were able to support their education (secondary or higher) thanks to having an income.

Young people participating in the volunteer program noticed an increase in their self-esteem and in respect from their peers and adults.

The Youth Positive Development model leverages existing social capital

With limited resources and with the need to cover a large number of young people, many governmental and non-governmental institutions acknowledged that the Goldtooth and Karate Kids videos, together with the "open-ended questions" approach, were powerful tools in developing trust and respect with street-active young people. Volunteers of the Red Crescent and World Vision of Uzbekistan, teachers and community activists, summer camp youth leaders and NGO staff all use the Street Choice (SC) component with young people. The SC tools provide an opportunity to discuss not only drug use, but also violence, crime, friendship, family relationships, gender and child labor issues. Volunteer involvement and training of colleagues multiplies the program's effect, without requiring additional funding. "He always has the Goldtooth cartoon in his bag. Each time he can spend an hour with young people, and there is access to a VCR, he would gather the kids around him and say: "Guys, I'd like you to watch this video, and discuss it ..." (one of the NGO leaders describing her colleague).

The Youth Positive Development model was accepted by organizations working on universal prevention

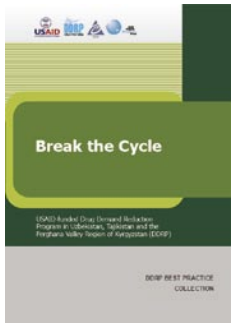
The DDRP sub-grantees in Uzbekistan and Tajikistan were introduced to the SC approach during the pre-project planning period. As a result, the SC components and volunteer model approach are used by many sub-grantees in the Sister to Sister program, or in the universal prevention project. Organizations such as the NGO Sadokat, Murod, DARK, the Drug Control Agency of Sughd province, and many others delivered the SC program to parents, law enforcement officials, community members and religious leaders.

Local communities support the organization of SC workshops for young people

In many places local community members invited facilitators to deliver SC workshops for their children. They would provide a space in their apartment or their garden, a TV set and VCR, and invite the young people of the mahalla for the workshop. In some places they would invite facilitators to deliver a workshop just in the street, using an extension cord for the VCR. In the Barakat Market in Dushanbe, the head of the market committee (*bazarkom*) provided the facilitators with space in the market to deliver workshops to the young porters (*arbokesh*) and paid for the coffee breaks. In Khujand, after a local NGO delivered SC workshops to working women, they took turns to show the videos to their children at home ("I'm not good at speaking to my kids. I'm too busy, and I don't know how to talk with them about drugs. This cartoon helped me to start a conversation with my older sons, and, it was a message to them: if you have any problems, it is safe to come to me for help," one of the mothers said).

BREAK THE CYCLE

Break the Cycle builds on existing drug demand reduction programs



Break the Cycle, working with IDUs, operates in collaboration with various programs including drug use prevention activities that target at-risk youth. The addition of BTC's IDU-focused work to existing youth-focused drug demand reduction activities provides a new, holistic model for drug demand reduction with a greater chance of successfully preventing people from initiating injection of heroin or other drugs. More conventional forms of drug demand reduction – i.e. drug use prevention education activities – assist non-drug users to understand the risks attached to drug use.

Countries facing HIV epidemics driven by injecting drug use should consider replicating BTC projects in order to reduce the number of young people initiated into injecting drug use. If implemented successfully, this model could have an important impact on reducing injecting drug use and the spread of HIV globally.

Break the Cycle builds on existing HIV prevention efforts

The Break the Cycle intervention operates primarily through an outreach education model to reduce IDU assistance to others to initiate injecting. Experienced outreach workers, already working with IDUs to provide HIV prevention messages and materials, used their contacts among current drug user networks to attract individuals to participate in BTC activities. These contacts allowed the projects to quickly reach a substantial proportion of injectors in the target sites; to add additional training for outreach staff on motivational interviewing – a core methodology used in BTC; and to add value to HIV prevention programs.

Break the Cycle also provides health assistance to drug users

The BTC trainings also benefited the drug users who participated. Drug users were attracted to education sessions by combining them with overdose prevention education which helped them learn how to avoid and/or manage overdose to reduce drug user morbidity and mortality. Ongoing contact with injecting drug users provided opportunities to motivate current users to move towards drug treatment and HIV testing. Significantly, many drug users reported a deep sense of gratitude to BTC outreach workers.

Break the Cycle builds on social codes among injecting drug users

Break the Cycle is not a program externally imposed upon drug users. Rather, it builds upon existing norms within networks of drug users that value efforts to limit the initiation of people into injecting. The social codes of acceptable behavior among existing drug users strongly influence the initiation of new users into injecting. The process of initiation into injecting is likely to influence an individual's future injecting practice and risk-taking behavior [13]. Research shows that most first-time injectors are eagerly and willingly involved in the decision to first inject, rather than being passive victims seduced into injecting drug use by experienced drug users [14]. However, experienced drug users do not generally intend to introduce non-injectors to injecting, and many refuse when asked [15]. The unwillingness to initiate new users represents a common social code found among experienced drug users. The BTC approach aims to reinforce this social code, and to disrupt the initiation of novices into injecting [16,17].

TREATMENT READINESS FOR DRUG USERS

DDRP treatment readiness approach was the first of its kind in Central Asia

The DDRP focus on treatment was both a unique and positive contribution to drug demand reduction and HIV prevention at all sites visited. Funded organizations suggested most projects related to injecting drug use in the region focused on needle exchange only rather than on encouraging individuals to get into treatment programs and on abstinence from drug use. Local professionals strongly praised DDRP for being the donor program in the region to move beyond risk reduction for injecting drug users.

Treatment readiness interventions targeted hard-to-reach populations

Treatment readiness projects aimed to decrease injecting drug use and HIV transmission through targeting drug users, including sex working drug users and youth. The projects demonstrated the effectiveness of outreach-based programs in reaching and motivating injecting drug users to change their risk behaviors.

Injecting drug users in Central Asia are difficult to reach: fear of arrest and harassment drives injecting drug users to avoid all contact with police and medical institutions. DDRP treatment readiness projects consciously developed relationships with police, government and health administrations to minimize harassment of injecting drug users seeking treatment.

Treatment readiness interventions led to significant benefits for individuals and codependents

Motivational interviewing, supported by credible, relevant education and information formed the backbone of treatment readiness projects. Education was undertaken through outreach, drop-in centers and outpatient services, and targeted both at drug users and their significant others such as family and spouses (referred to here as codependents). As an indicator of the popularity of treatment readiness activities, most organizations visited in the development of this model stated that they had underestimated the client demand for treatment readiness services in the project planning phase.

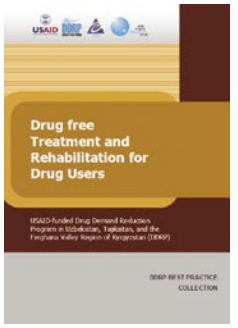
Treatment readiness projects demonstrated the value of anonymous referral networks

Treatment readiness implies the availability of treatment and rehabilitation. Close relationships between DDRP treatment readiness projects and DDRP-funded Drug free treatment and rehabilitation services were noted in all organizations. Treatment readiness projects drew together drug demand and risk reduction activities into a unified approach within a defined geographical region. The projects demonstrated the value of linking drug treatment readiness, HIV prevention, drug treatment and rehabilitation in an active and anonymous referral network. An individual could obtain appropriate services and then be assisted by program staff to move to any other appropriate programs.

DRUG FREE TREATMENT AND REHABILITATION FOR DRUG USERS

Provision of anonymous services

Anonymous service provision was critical to the success of the DDRP Drug free Treatment and Rehabilitation for Drug Users Model. The projects demonstrated the effectiveness of close integration with outreach-based treatment readiness in motivating injecting drug users with education, advice and referrals aimed at changing their risk behaviors [18].



The Unique Identifier Code (UIC) developed through DDRP allowed clients to be referred anonymously and receive free treatment and rehabilitation anonymously. The UIC was part of a comprehensive system within DDRP's Drug free Treatment and Rehabilitation that ensured client anonymity when working with at-risk and drug-using populations. This was particularly the case in service locations outside national capitals, where significant stigma and discrimination associated with drug use and HIV can affect not only clients but also their families (Please

refer to the DDRP UIC Model in this series for additional information.)

By contrast, government drug treatment (narcology) clinics require individuals to be registered as drug users ("*na uchyote*"). Further, treatment in government run drug treatment clinics consists of short–term pharmacologically-assisted detoxification only. Many medical staff and clients regard compulsory registration of drug users and detoxification-only approaches as significant disincentives to enter government funded drug treatment.

Anonymous Drug free treatment and rehabilitation was offered at all sites and universally praised by both clients and medical staff as one of the most important incentives leading drug dependent individuals to seek help for drug use.

DDRP projects were evidence based interventions tailored to local environments

Local professionals strongly praised DDRP for extensively supporting rehabilitation and providing effective training in contemporary treatment techniques. These projects (together with other DDRP projects such as treatment readiness and those addressing sex workers) provided a continuum of care from outreach work through to treatment and reintegration into society. In addition to successfully building capacity among local drug treatment professionals, the DDRP projects provided an opportunity for interventions to be modified to local conditions. For example, at several sites in southern Kyrgyzstan, rehabilitation projects were oriented toward manual labor rather than cognitive methods after testing the usefulness of various approaches.

Benefits to individuals

The Drug free treatment and rehabilitation projects offered drug dependent individuals significant benefits. Central to reducing the demand for drugs is the treatment of dependent drug users. However, drug treatment in most Central Asia countries generally remains limited by Soviet-era detoxification-only practices and a lack of resources. In addition to anonymity, the extended-stay residential programs provided clients with genuine opportunities to cease injecting drug use. Aside from government drug treatment programs, the DDRP projects were the only no-cost option available in Uzbekistan, Tajikistan, and Kyrgyzstan.

The projects' focus on integration of cognitive, medical and social aspects of drug treatment and rehabilitation was consistent with international evidence. Rather than clients being forced back into their previous lives at the end of a course of rehabilitation, relapse prevention interventions such as halfway houses and 12 step interventions were incorporated into most projects. The DDRP Drug free Treatment and Rehabilitation approach was widely praised by drug treatment staff and clients as a unique project that offered clients a "way out of the labyrinth."

Benefits to families and codependents

In each DDRP project reviewed, education was undertaken in residential therapeutic communities, and targeted both at drug users and codependents (including families of drug users). Family conflict is generally regarded as exacerbating drug dependence. Limited contact with families and codependents was permitted at all sites. Codependents' relationships with the drug user may influence the drug user's behavior, and counseling interventions were therefore regarded as an important part of the rehabilitation intervention at all sites.

View of opiate dependence as a chronic relapsing disease

Within the DDRP Drug free Treatment and Rehabilitation projects, interventions focused on motivating individuals toward long-term abstinence from drug use. While all projects sought to equip clients with the cognitive and emotional resilience to withstand relapse, international evidence suggests injecting drug use is closer to a chronic disease than a temporary affliction [19].

The chronic relapsing nature of opiate dependence is caused by a confluence of genetic, biological, behavioral and environmental factors. Detoxification treatment alone fails to address the complex factors underlying and surrounding the disorder. Heroin use also produces long-term biological changes, as well as medical, social and occupational difficulties that put former drug users at great-risk of relapse. Treatment should thus be considered a long-term process. Moreover, poverty, psychiatric problems and lack of social supports all increase the chances of relapse after treatment. The difficult social and economic conditions in Central Asia and trauma following events such as the civil war in Tajikistan also make it more difficult for people to stop using drugs.

Rather than punishing drug users with expulsion, individuals seeking to resume Drug free treatment would be readmitted, subject to several conditions. At Musaada in Kyrgyzstan, for example, clients were readmitted to the next group if breach of contract or relapse occurred, based on testing of their urine tests to confirm their drug free status.

LESSONS LEARNED

This section of the Drug Demand Reduction Project Model provides an overview of general recommendations and lessons learned from DDRP projects and Models.

Part of a comprehensive approach

Utilizing two frameworks – the Spectrum of Services (see www.aidsprojects.com and Appendix) and the notion of selected, indicated and universal prevention – has allowed DDRP to ensure that a wide range of services and modes of service delivery have worked together towards specific strategic objectives (see www.ddrprogram.org and Figure on page 3).

Whether a DDRP component is providing drug demand reduction education to young women while increasing their capacity to bake foods they can sell at markets or providing Drug free rehabilitation to active injecting drug users or assisting youth not to initiate injecting, all DDRP activities have worked towards reducing drug use, drug injecting and the common problems associated with heroin injecting such as HIV infection, overdose and drug dependence.

By seeing their work within a structured, strategic framework, each organization participating in DDRP activities has learned more about the relationship between drug use and HIV infection in the region and, at every level from local to inter-country, about the need for referral and communication between DDRP activities and other activities related to drug use and HIV infection.

Any future programs aimed at further reducing the demand for drugs – especially reducing heroin injecting – should follow a similar path by using a similar set of frameworks to guide all program activities. Regular communication about these frameworks between partner organizations

and to and between grantees and sub-grantees will ensure that activities are operating towards the same broad objectives.

Taking into account specific country characteristics

Basing program activities on a comprehensive assessment ensured that target groups were defined within the specific characteristics of each Central Asian country. For example, the vulnerability of migrants in Tajikistan is so significant that this group became the focus of many different activities including the Drug free Spaces projects, the Sister to Sister projects implemented in that country. The need for Drug free treatment and rehabilitation was so great in Kyrgyzstan that many of the projects there concentrated either on directly providing this treatment or on treatment readiness to assist active injectors into treatment. In Uzbekistan, a wide range of target groups was defined and this was matched by a wide range of programs.

The assessment found similarities between the three countries as well and this allowed the partner organizations, through their regular meetings, to ensure that a tailored national approach in each country also led to regional information-sharing and discussion that improved the quality of project activities. At the local level, all of the Models have noted the importance of working with mahallas and other forms of local authority: only by ensuring that local authorities understand the need for project activities will those activities succeed. Future Central Asian programs addressing these topics should take a similar approach that works at the local, national and regional level.

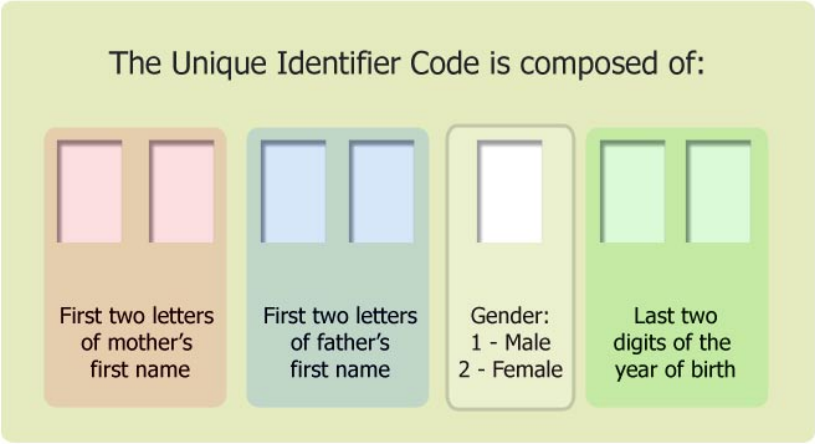
Political issues were important in all three countries in determining the timing of interventions and in gaining community support for DDRP activities.

Establishing common monitoring tools

Due to many factors, it took a considerable period to develop common monitoring tools and indicators for DDRP across the board though partner organizations carried out their own monitoring from the beginning of the project. The time spent on developing and fine-tuning the Unique Identifier Code, in particular, appears to have provided wide benefits for the region as it is now in use by all organizations working with DDRP funding as well as many other national and regional programs.

Future drug demand reduction programs should build on this solid base

and ensure that monitoring processes and capacity building in using standardized monitoring tools are provided to all partners and grantees before or in the early stages of implementation. It is also important to marry the monitoring and evaluation methods used for drug demand reduction ac-



tivities with those being developed for HIV-related activities as there is a strong connection between drug injecting and HIV infection in the region.

Capacity development for sustainability

Great emphasis has been placed on capacity building within the DDRP. Those trained in the various workshops, courses and mentoring activities work in a variety of governmental and non-governmental settings and include health professionals, police, prisons staff, and community leaders. This emphasis on capacity building means that substantial work can continue after DDRP ends.

The capacity build by DDRP needs to be quickly matched with program funds so that the skills and knowledge acquired can be put to use to address drugs and HIV issues. With the closure of DDRP, regional funds for drug demand reduction will fall significantly and it is likely that trainees will move to other work where funding is secured. Future efforts to address drug use in Central Asia should build on this capacity building process and expand training and other activities to achieve full coverage of all relevant professionals in all Central Asian countries.

Partnerships between organizations at several levels

Partnerships have been vital to the effectiveness of DDRP activities. Partnerships have been formed between international organizations, with national partners, and with other regional and national programs. It is important to point out that a great deal of knowledge and skill is already in place within organizations in each Central Asian country covered by DDRP: much of the project's work has been to harness existing skills and apply them to new components through capacity building, funding and technical assistance.

Difficulty with restricted focus

Another lesson is that it has been difficult for DDRP to work only in the Ferghana Valley region of Kyrgyzstan, centered on Osh. Given the similarities in the situation of drug use and related HIV infection between Osh and Bishkek and between rural areas of the Ferghana Valley and some other areas of the country (such as Chui Oblast), it was difficult for DDRP partners to justify their focus only on one area. Future programs should be national in each country they address to ensure that these difficulties do not arise.

Summary of lessons learned

The DDRP target countries have all experienced significant social turmoil since the late 1980s. The break-up of the USSR, poverty and large-scale movement of individuals and groups destroyed economic and other institutions, inflicted trauma on populations, and reshaped the social influence and social support networks that form the basis of normative regulation in communities. People who had spent their whole lives in relatively small communities surrounded by relatives, long-term friends, and elders found themselves forced to migrate to other settings in which none of these supports were present. This greatly increased the probability that some of them would undertake previously taboo forms of activity such as drug use, sex, theft and violence. The experience of living through social turmoil may have discredited some previously unquestioned rules of conduct, while the effects of trauma might weaken individuals' ability to live up to such rules of conduct even if they continue to believe in them. Youth who grow up in such circumstances are likely to form friendship networks that develop their own norms with less supervision and less transfer of so-

cial values and behaviors. In many post-Soviet places, some of these youth networks have accepted high-risk sex, high-risk drug use, and sex trading as legitimate activities [20].

DDRP empowered Central Asian communities by involving them in defining their needs and strategies at every stage of program and policy development. Where regions lacked sufficient public health education, clinical and social services, drug treatment and rehabilitation services, resource identification and capacity building became a major facet of programming. Treatment and rehabilitation of drug users were key elements, recognizing that no single program approach could work for everyone.

Through many dedicated NGO staff, doctors, teachers, drug users, ex-users and their families and friends across numerous local projects, DDRP has concentrated on changing behavior in the specific contexts in which drugs are used, based on a thorough understanding of drug related beliefs, knowledge, practices, and norms. This adaptation and responsiveness to differences in local conditions produced lessons learned, and successes, detailed in the other nine models in this series.

Home Page of the DDRP website

www.ddrprogram.org

The DDRP website went online in January 2005.
It contains comprehensive information on DDRP partners, goals and activities, Program components (grants, trainings etc.) and a review of activities by country.
DDRP publications including Program e-journal, DDRP models, reports, photo and video materials are also available. Along with full contact details, the website provides a list of centers and NGOs engaged in drug use and HIV/AIDS prevention in the region.
The DDRP website is available in English and Russian.

GLOSSARY

Anasha: Cannabis derivative.

Drop-in center: A drop-in center is a site that provides drug demand reduction services to a specific target group, such as individuals in at-risk groups, active drug users and commercial sex workers. While some drop in centers aim to facilitate social contact between clients and professional staff, other centers may offer at-risk individuals services such as food, washing and sleeping facilities. Drop-in centers for drug demand reduction generally aim to provide "low threshold services". That is, they have very open criteria and allow anyone who wishes to visit the center to do so.

Drug demand reduction: The term "drug demand reduction" is used to describe policies or programs directed towards reducing the consumer demand for narcotic drugs and psychotropic substances covered by the international drug control conventions (the Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol, the Convention on Psychotropic Substances of 1971 and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988). The distribution of these narcotic drugs and psychotropic substances is forbidden by law or limited to medical and pharmaceutical channels [21].

Mahalla: Traditional Central Asian local neighborhood structure, with limited responsibilities for local affairs including family welfare and minor disputes.

Narcology: The Soviet and Post-Soviet system for drug addiction study and treatment.

Narcological dispensary: Drug and alcohol treatment clinic.

Narcologist: Medical drug and alcohol treatment specialist.

Na uchyote: To be registered as a drug user by a government narcology service.

Propiska: Internal registration noted in passport that provides authorization to live, work and obtain medical services at a particular location.

Province: Administrative sub-division analogous to a province or state. A level of administration is associated with this level of government.

Social skills training: A general term for instruction conducted in behavioral areas that promotes more productive and positive interaction with others, and in so doing, promotes social acceptance.

Social workers: The term outreach worker and social worker are used interchangeably. Social work as an academic discipline is at an early stage of development in Central Asia, and most social workers have not completed degrees in the discipline.

APPENDIX

Map of all sites at which DDRP projects were implemented

SPECTRUM OF SERVICES TO ADDRESS INJECTING DRUG USE & HIV INFECTION

AIDS Projects Management Group

Needle/syringe programs

TARGET	Injecting drug users including sex working injectors
ACTIVITIES	Education Needle & Syringe provision Needle & syringe disposal Provision of other injecting equipment Training in less risky drug injection Preventing injecting initiation Treatment readiness Counselling relating to drug and HIV issues Advocacy
DELIVERED BY	Fixed site NSPs Outreach NGOs Polyclinics Prisons Drug treatment services Accident/emergency departments Family doctors Pharmacists

Condom use/Safer sex programs

TARGET	Drug injecting sex workers, drug users, prisoners, at-risk youth & pre-injectors, gatekeepers for sex workers (pimps, drivers, etc.)
ACTIVITIES	Education Condom distribution Training in safer sex negotiation Negotiation with gatekeepers Counselling related to drug and HIV issues Advocacy
DELIVERED BY	Fixed site NSPs Outreach NGOs Polyclinics Prisons Drug treatment services Pharmacists Family doctors Youth centres Schools Youth detention centres Youth-friendly clinics STI services

Police assistance

TARGET	Illicit drug users and sex workers (where sex work is illegal)
ACTIVITIES	Education Referral to NSP/treatment/ other components Differential treatement for drug users and drug traffickers Drug courts/diversion to treatment Legal changes Advocacy
DELIVERED BY	Police Law courts

Drug treatment (non-substitution)

TARGET	Drug users, including drug using youth and drug injecting sex workers
ACTIVITIES	Education Outpatient &inpatient care using a range of modalities Assisting clients to choose drug treatment services that match their treatment goals Counselling related to drug and HIV issues Organising and training ex drug users Advocacy
DELIVERED BY	NGOs Prisons Drug treatment services Youth detention centres Youth-friendly clinics Family doctors

Socio-legal support

TARGET	Drug users, sex workers, at-risk youth, pre-injectors, prisoners and detainees
ACTIVITIES	Education Social and legal support using a range of modalities Counselling related to drug and HIV issues Organising and training drug users Advocacy
DELIVERED BY	Youth detention centres Youth centres Outreach NGOs Social services Legal organisations Fixed site NSPs Drug treatment services STI services Prisons

Safe spaces

TARGET	Injecting drug users and sex workers
ACTIVITIES	Education Counselling related to drug and HIV issues
DELIVERED BY	NGOs Fixed site NSPs

VCT

TARGET	Injecting drug users and sex workers
ACTIVITIES	Education Pre and post-test counselling HIV tests
DELIVERED BY	VCT centres Counselling Outreach NGOs Drug treatment services STI services Polyclinics Youth centres Youth-friendly clinics

HIV/Hep/TB Treatment Care Support

TARGET	PLHA, including HIV-positive injecting drug users and sex workers
ACTIVITIES	Education Assisting clients to choose HIV treatment, care and support services that match their needs Outpatient &inpatient care Counselling related to drug and HIV issues Organising and training PLHA Advocacy
DELIVERED BY	Outreach NGOs Drug treatment services STI services Polyclinics Youth centres Youth-friendly clinics

Pre-release

TARGET	Prisoners and detainees, including sex workers, drug users, at-risk youth & pre-injectors
ACTIVITIES	Education Assisting clients to choose programs that can provide assistance after release from prison Counselling related to drug and HIV issues Advocacy
DELIVERED BY	Prisons Youth detention centres

Post-release

TARGET	Ex-prisoners and detainees, including sex workers, drug users, at-risk youth & pre-injectors
ACTIVITIES	Education Assisting clients to participate in programs that can provide assistance after release from prison Counselling related to drug and HIV issues Advocacy
DELIVERED BY	Youth-friendly clinics Youth centres Outreach NGOs Fixed site NSPs Drug treatment services STI services Polyclinics Pharmacists

Treatment readiness

TARGET	Drug users
ACTIVITIES	Counselling Motivational interviewing Assessment and referral
DELIVERED BY	Fixed site NSPs Outreach NGOs Polyclinics Prisons Drug treatment services Youth centres Youth detention centres Youth-friendly clinics STI services

Drug treatment (substitution)

TARGET	Opioid users including injectors
ACTIVITIES	Education Methadone maintenance treatment Counselling related to drug and HIV issues Organising and training methadone consumers Advocacy
DELIVERED BY	Prisons Drug treatment services Youth detention centres Youth-friendly clinics

STI treatment

TARGET	Sex workers drug users at-risk youth & pre-injectors
ACTIVITIES	Education STI diagnosis and treatment Counselling related to drug and HIV issues Advocacy
DELIVERED BY	Outreach NGOs STI services Youth-friendly clinics

Primary health care

TARGET	Drug users at-risk youth & pre-injectors
ACTIVITIES	Education Outpatient and inpatient health care Hepatitis B vaccination Naloxone provision Counselling related to HIV issues Advocacy
DELIVERED BY	Youth-friendly clinics Youth detention centres NGOs Drug treatment services STI services Polyclinics Accident/emergency departments Family doctors Prisons Fixed site NSPs

Self-support for PLHA

TARGET	PLHA, including HIV -positive injecting drug users and sex workers
ACTIVITIES	Education Assisting clients to choose HIV treatment, care and support services that match their goals Counselling related to drug and HIV issues Organising and training PLHA Advocacy
DELIVERED BY	NGOs Fixed site NSPs Drug treament services STI services Youth-friendly clinics

Prevention of drug use/injecting

TARGET	At-risk youth & pre-injectors
ACTIVITIES	Education Alternatives to drug use Health services designed to attract youth Counselling related to drug and HIV issues Advocacy
DELIVERED BY	NGOs Outreach Youth centres Schools Youth-friendly clinics Youth detention centres Drug treatment services

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